FAMILY DENTISTRY

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

PERSONAL

Patient Name _____
Last First MI (Preferred)

Birthdate _____ SS# _____Gender: [ ] M [ ] F Married: [ ] Y [ ] N

Cell Phone _____ Email: _____

How did you hear about us? Google YELP Facebook Drive-By Mailer/Flier Shopping in Complex

Person/Other:_____

ADDRESS AND HOME PHONE

Check box if same for entire family: [ ]

Address _____

City _____ State _____ Zip _____ Home Phone _____

INSURANCE POLICY 1

Patient relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Subscriber Name _____ Subscriber ID# _____ Subscriber DOB _____

Insurance Company _____ Phone _____

Employer _____ Group Name _____ Group # _____

FINIANCIAL AGREEMENT & ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

- For my convenience, this office may release my information to my insurance, and receive payment directly from them.
- If sent to collections, I agree to pay a $30 collection fee, all related fees and court costs.
- Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible.
- Treatment plans may change, and I will be responsible for the work actually done
- I have had the full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke permission.

MEDICAL HISTORY

Emergency Contact _____Phone _____ Relationship_____

List all the medications or drugs you are now taking:

[ ] None
_____
_____
_____
_____

Check mediations or drugs you are allergic to:

[ ] None
[ ] Aspirin
[ ] Codeine/Other Narcotics
[ ] Erythromycin
[ ] Latex Rubber
[ ] Local Anesthetics
[ ] Metals
[ ] Penicillin
[ ] Sulfa Drugs
[ ] Other: _____

Check any medical condition you may have:

[ ] None
[ ] AIDS/HIV
[ ] Alcohol/Drug Abuse
[ ] Anemia/Leukemia
[ ] Anorexia/Bulimia
[ ] Arthritis
[ ] Asthma/Hay Fever
[ ] Blood Clotting Problems
[ ] Blood Transfusion
[ ] Bronchitis
[ ] Cancer/Tumor or Growth
[ ] Cardiac Pacemaker
[ ] Chest Pain Upon Exertion
[ ] Damage Heart Valve
[ ] Other: _____
[ ] Diabetes
[ ] Emphysema
[ ] Epilepsy
[ ] Fainting Spells/Seizure
[ ] Fever Blisters/Herpes
[ ] Frequent Headaches
[ ] Frequently Dry Mouth/Sjogren
[ ] Gall Bladder Trouble
[ ] Heart Attack/Stroke
[ ] Heart Disease/Angina
[ ] Heart Murmur
[ ] Hepatitis/Jaundice
[ ] High Blood Pressure
[ ] Hives/Skin Rash
[ ] Joint Replacement, Date of: _____
[ ] Kidney/Bladder Trouble
[ ] Liver Disease
[ ] Low Blood Pressure
[ ] Mental Health Problems
[ ] Mitral Valve Problems
[ ] Persistent Diarrhea
[ ] Rheumatic Fever
[ ] Rheumatic Heart Disease
[ ] Sexually Transmitted Disease
[ ] Sinus Trouble
[ ] Stomach Ulcers
[ ] Stomach Ulcers
[ ] Tuberculosis

WOMEN ONLY: Are you pregnant or do you have reason to believe you may be? [ ] Yes / [ ] No

New Patients:
Name of former dentist _____ City/State _____

Date of last cleaning and exam? _____

Unusual reaction to dental injections? _____

Reason for today's visit: _____ Are you in pain? Yes / No

By Signing below, I certify that all the above information is true to the best of my knowledge.

X _____ X _____

Patient/Gaudian Name (**Printed**) Date

X _____

Patient/Gaudian Name (**Signature)**